PROPOSED AMENDMENT TO THE
TENNCARE DEMONSTRATION PROJECT
OFFICE OF THE GOVERNOR
STATE OF TENNESSEE
DECEMBER 8, 2005

I. Background

Over the last year, Tennessee has worked to regain control over the explosive growth in TennCare spending that has threatened to crowd out all other state programmatic and policy priorities. Earlier this year, Tennessee was reluctantly forced to propose the disenrollment of certain TennCare enrollees as well as to propose changes to the TennCare benefit package for all TennCare adults in order to achieve savings necessary to ensure that the program remained financially viable. The Centers for Medicare and Medicaid Services (CMS) responded to Tennessee's request and approved Tennessee's proposed amendments to the TennCare Demonstration Project on March 24, 2005 and June 8, 2005. Among the individuals targeted for disenrollment were approximately 97,000 non-pregnant Medically Needy adults.

At the time of these amendments, however, the State remained committed to maintaining some level of coverage for the adult non-pregnant Medically Needy population in the event that the State was able to overcome legal obstacles to necessary TennCare reforms. Both before and after the creation of TennCare, several lawsuits were filed against the State and its Medicaid program. One of these lawsuits, *Rosen v. Commissioner of Finance and Administration* (*Rosen*), resulted in an Agreed Order imposing obligations upon the State with respect to due process rights for persons applying for TennCare or being disenrolled from TennCare. Another lawsuit, *Grier v. Goetz* (*Grier*), resulted in a Consent Decree that imposed due process requirements upon the State and its contractors beyond what is required under federal law or under the terms of the TennCare Demonstration Project. These *Grier* requirements have significantly hindered the State's ability to effectively implement a prior authorization system, thereby contributing to the fact that TennCare has the highest drug utilization levels of any state Medicaid program.

Earlier this year, the State initiated legal action seeking certain modifications of the *Grier* Consent Decree that would allow the State to implement reforms necessary to control some of the significant costs of the TennCare program. Prior to the court hearing, the State entered into a Memorandum of Understanding (MOU or agreement) with counsel for the Plaintiffs-Intervenors. In this agreement, the State pledged to establish a new *waiver-based* Medically Needy program to provide coverage for the neediest enrollees who will be losing TennCare coverage under the State's TennCare reform plan, if the court granted the State's request for modifications of the *Grier* Consent Decree and the State was not subject to any additional delay under the *Rosen* Consent Decree.

In August and November 2005, the court granted a number of the State's requests to modify the *Grier* Consent Decree. In May 2005, the Sixth Circuit also affirmed the State's right to proceed with the disenrollment of TennCare enrollees as approved by CMS and consistent with federal law. As a result, the State is now in a position to move forward with the agreement it reached with counsel for the Plaintiffs-Intervenors to forego the planned disenrollment and instead

continue to provide a program for the majority of the adult non-pregnant Medically Needy population. Under the terms of the agreement, the State had contemplated extending coverage for these individuals as part of a demonstration-based spend down program. Thus, although coverage for these individuals would remain comparable to the coverage individuals receive as part of the Medically Needy population, the demonstration-based program would impose additional restrictions designed to ensure limited state resources were focused on those individuals most in need of medical coverage.

After consultation with counsel for the Plaintiffs-Intervenors, the State has decided to implement its commitments under the agreement more quickly and with broader eligibility criteria by maintaining coverage for the adult non-pregnant Medically Needy within the State's core Medicaid program. More recently, the financial outlook for the TennCare program has begun to improve with the advent of legal relief allowing the State to implement necessary TennCare reforms and to better manage the delivery of the TennCare pharmacy benefit. We anticipate this budgetary trend to continue as the managed care organizations (MCOs) return to a shared risk arrangement incorporated into recently approved contract amendments that incentivize the MCOs to control utilization and costs. Assuming broader reform efforts are not further delayed by advocate litigation, the State is also prepared to open new enrollment to those not currently eligible for TennCare during the current state fiscal year 2006 (SFY06).

Accordingly, we are pleased to submit this proposal to amend the TennCare Demonstration Project to facilitate the re-institution of coverage for the adult non-pregnant Medically Needy under the State's existing Medically Needy program.

II. Public Input

Tennessee has collaborated with stakeholders in developing this proposal. The State has formulated this proposal pursuant to its agreement with Plaintiffs-Intervenors who represent the interests of the TennCare enrollees who are facing disenrollment. This proposal, therefore, explicitly incorporates the input of the representatives of this class of individuals. On December 8, the State also released a draft of this proposal to the public as well as the Medical Care Advisory Committee (MCAC), the TennCare Oversight Committee and the Tennessee Justice Center.

III. Proposed Amendment to the TennCare Demonstration Project

A. Recently Approved Eligibility Reforms

On March 24, 2005, Tennessee received approval from CMS to disenroll TennCare Standard adults and non-pregnant Medically Needy adults. The State also received approval to close enrollment for the adult non-pregnant Medically Needy and to close enrollment for open TennCare Standard categories including "rollover" enrollment from TennCare Medicaid to the TennCare Standard population for individuals age 19 and older.

The State has implemented some but not all of this authority. On April 29, 2005, the State implemented its authority to close enrollment for the adult non-pregnant Medically Needy and to close enrollment for open TennCare Standard categories, including "rollover" enrollment from

TennCare Medicaid to TennCare Standard for individuals age 19 and older. Beginning on June 6, 2005, the State began the disenrollment process for TennCare Standard adults and a number of these enrollees have been disenrolled unless they have appealed their termination. Beginning on June 30, 2005, the State also began sending out Requests for Information (RFIs) to those adult non-pregnant Medically Needy who had reached the end of their current year of eligibility.

The State, however, then halted the implementation of its authority to disenroll adult non-pregnant Medically Needy enrollees. Having achieved significant legal relief from some of the restrictions previously imposed by the *Grier* Consent Decree and with early reform efforts showing promising savings, the State decided to extend TennCare coverage for non-pregnant Medically Needy adults who would otherwise be disenrolled at the end of their one year of eligibility pending CMS review of this proposal. (At this juncture, however, the State has begun the disenrollment process for adult non-pregnant Medically Needy enrollees who are eligible for Medicare and who are not receiving long term care services, as these individuals will receive Medicare coverage for prescription drugs as of January 1, 2006.)

B. Proposed Actions

Because the adult non-pregnant Medically Needy population are the most vulnerable of the individuals previously scheduled to be disenrolled, the State is now seeking to ensure that the majority of these individuals remain eligible for the TennCare program. Under the terms of this proposal, currently eligible individuals, with the exception of certain dual eligibles, will have the opportunity to extend their coverage as Medically Needy for at least an additional year. Enrollment into the Medically Needy program also will be opened to new applicants (with the exception of those who may qualify for Medicare), subject to a limit on the number of individuals who may be deemed eligible. This enrollment cap allows the state to provide coverage to as many Medically Needy individuals as possible; while remaining committed to ensuring the long term overall financial viability and stability of the TennCare program.

In providing coverage for these individuals as part of the existing Medically Needy program, the State proposes to apply the following criteria:

- **Eligibility**
    - Application of the current eligibility criteria already in place for Medically Needy children and pregnant women. Such criteria include: (i) eligibility period of 12 months; (ii) resource limit equivalent to $2,000 per individual and $3,000 per couple subject to certain exceptions; and (iii) individuals who apply and qualify as Medically Needy will only be granted retroactive eligibility to the date of application or after spend down is met, whichever is later. In determining eligibility, the State will consider deductible incurred expenses consistent with federal law. (For example, for new applicants, the State will limit deductible expenses to those incurred within the past 90 days.)

- **Enrollment**

The proposed enrollment criteria and process for the re-established adult non-pregnant Medically Needy category will depend upon whether an enrollee falls into one of the four categories referenced below. (For ease of reference, we will refer to this adult non-pregnant Medically Needy category as Adult MN.)

- *Currently Enrolled Adult Non-Pregnant Medically Needy (Category 1):* Approximately six weeks after receiving CMS approval, the State plans to re-open enrollment for Adult MN for those individuals who are enrolled as adult non-pregnant Medically Needy at that time (except those in Category 4). The State will redetermine the eligibility of these individuals to confirm whether they may remain eligible as Medically Needy for an additional 12 months. If these individuals are not found eligible for Medicaid during this redetermination, they will be disenrolled; but will be able to re-apply for Medicaid. For the remainder of SFY06, these individuals will be able to re-apply for Adult MN without being subject to any enrollment cap. In SFY07, however, these individuals may only re-apply for Adult MN in the same manner as Category 2 applicants, which is subject to an enrollment cap.

- *New Applicants for Adult MN (Category 2):* Approximately six weeks after receiving CMS approval, the State plans to initiate periods of open enrollment for Adult MN for new applicants. Applications will be accepted unless and until enrollment in Adult MN reaches 100,000. New enrollment in Adult MN, however, will not be open to any individuals who are eligible for Medicare (including those in Category 4). Because Medicare-eligible individuals are transitioning to coverage under Medicare Part D, a substantial number of slots in Adult MN should be available for new applicants. The State will engage in a communications campaign to ensure that the general public is aware of periods of open enrollment.

- *Grandfathered Medically Needy Dual Eligibles (Category 3):* Adult non-pregnant Medically Needy who are dually eligible for Medicare and Medicaid and who are receiving long term care services will be grandfathered into Adult MN, which means that these individuals will be subject to the same enrollment and redetermination processes as individuals in Category 1.

- *Other Medically Needy Dual Eligibles (Category 4):* With the exception of individuals in Category 3, no adult non-pregnant Medically Needy enrollees who are or become Medicare eligible may apply for Adult MN. Instead, these individuals will only be able to re-apply for Medicaid categories other than Adult MN.

- **Benefits**

    - The benefit package for Adult MN will be the same as the benefit package currently approved for TennCare's adult Medicaid population. These benefits will include long-term care services and pharmacy coverage. Pharmacy coverage will be subject to applicable limits (five prescriptions per month -- two branded and three generic), with the exception of enrollees receiving long term care services who will have unlimited pharmacy coverage. With the exception of certain populations, enrollees will have nominal cost sharing for prescription drugs.

IV. Legal Authority

TennCare has been operating since January 1994 pursuant to waivers of several statutory and regulatory requirements. A new demonstration project was granted in 2002 to allow changes in the TennCare program. New demonstration amendments were also granted in March and June of 2005 to provide the State with additional authority to reform the TennCare program. In addition to maintaining existing waivers granted to date, Tennessee is now requesting modification of certain waivers to facilitate the maintenance of coverage for the adult non-pregnant Medically Needy as part of Tennessee's current Medically Needy program as described above. To the extent that CMS believes that additional legal authority is required to implement the changes described in this proposal, Tennessee is also hereby requesting such authority, which would include but not be limited to any necessary changes to the TennCare Demonstration Project's Special Terms and Conditions.

A. Modification of Existing Waivers

Comparability of Eligibility	Section 1902(a)(17)
Simplicity of Administration	Section 1902(a)(19)
Description of Eligibility for Categories of Medically Needy	Section 1902(a)(10)(C)
Eligibility for all Individuals Described in State Plan	Section 1902(a)(8)

To enable the State to re-open enrollment and to establish an enrollment cap of 100,000 for the Aged, Blind, Disabled and Caretaker Relative Medically Needy categories, as defined in the State Plan, who are (i) age 21 and older, (ii) not pregnant and (iii) not dually eligible for Medicare and Medicaid unless they are grandfathered as dual eligibles receiving long term care services.